Memorandum

Date FEB - 9 2001

From Michael F. Mangano
Acting Inspector General

Subject Implementation of Medicare's Postacute Care Transfer Policy at First Coast Service Options (A-04-00-02162)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

Attached are two copies of the U.S. Department of Health and Human Services, Office of Inspector General's final report entitled, "*Implementation of Medicare's Postacute Care Transfer Policy at First Coast Service Options.*"

Our review examined the implementation of Medicare's transfer policy which may reduce inpatient payment rates when prospective payment system (PPS) hospitals discharge beneficiaries in 10 specified diagnosis related groups (DRG) to certain postacute care settings; i.e., skilled nursing facilities, PPS-exempt hospitals or units, and home health agencies.

Our review indicated that the payment system at First Coast Service Options (FCSO), which is a fiscal intermediary (FI) for the State of Florida, properly reduced payments to hospitals for claims related to the 10 specified DRGs which were coded as transfers to postacute care settings by the hospitals. However, we did find that overpayments resulted when the hospitals erroneously coded the claims as discharges instead of transfers.

Our review indicated that for the period October 1, 1998 through September 30, 1999, 26 of 100 sampled claims from the 10 specified DRGs coded as a discharge to home were erroneously coded because the beneficiary subsequently received postacute care. At the time of our review, the remaining 74 sampled claims were found to be appropriately reimbursed. Based on the sample results, we estimate that hospitals serviced by FCSO erroneously coded claims resulting in an overpayment for 26 percent of all "discharge to home" claims for the 10 specified DRGs.

The 26 erroneously coded claims in our sample resulted in excessive DRG payments of $37,788. Projecting this result to the 5,404 claims in our universe, we estimate that hospitals received $2,042,060 in excessive DRG payments as a result of these erroneous codings. These overpayments occurred because controls were not in place to ensure that the discharge code on the Medicare claim was correct.

As a long-term remedy, we recommend that the Health Care Financing Administration (HCFA) establish edits in its common working file (CWF) to compare beneficiary inpatient claims potentially subject to the postacute care transfer policy with subsequent postacute claims. This will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claim.

Pending implementation of CWF edits, we recommend that HCFA adopt these interim remedies:

- Issue a memorandum alerting FIs to the problems identified in our review and direct the FIs to re-emphasize to hospitals the importance of appropriate discharge status coding, with particular attention given to physician education regarding subsequent home health care.

- Instruct FIs to implement system edits in their system to identify inappropriately coded discharges when a postacute care claim is received. This would be applicable for claims for which the FI processes both the inpatient and postacute care claims.

- Instruct FCSO to recover the $37,788 in overpayments identified in our sample.

- Conduct a match using the CWF for the remainder of claims (totaling 5,304 claims) identified in our sampling universe of claims coded as discharges to home to identify and recover additional overpayments.

In partnership with HCFA, Office of Inspector General audit staff will assist FCSO in implementing the last recommendation.

In response to our draft report, HCFA officials concurred with our recommendations. We are expanding our audit work to additional FIs to further quantify the magnitude of inappropriately coded claims. We are looking forward to working with HCFA to ensure claims subject to the postacute care transfer policy are properly identified and reimbursed.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-04-00-02162 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IMPLEMENTATION OF MEDICARE'S POSTACUTE CARE TRANSFER POLICY AT FIRST COAST SERVICE OPTIONS

FEBRUARY 2001
A-04-00-02162

FEB - 9 2001

Memorandum

Date

From Michael F. Mangano
Acting Inspector General

Subject Implementation of Medicare's Postacute Care Transfer Policy at First Coast Service Options (A-04-00-02162)

To

Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

This final report provides you with the results of our review of Medicare's postacute care transfer policy at First Coast Service Options (FCSO), a fiscal intermediary (FI) for the State of Florida.

Our review examined the implementation of Medicare's transfer policy which may reduce inpatient payment rates when prospective payment system (PPS) hospitals discharge beneficiaries in 10 specified diagnosis related groups (DRG) to certain postacute care settings; i.e., skilled nursing facilities (SNF), PPS-exempt hospitals or units, and home health agencies.

EXECUTIVE SUMMARY

The objective of this review was to examine the appropriateness of payments made by FCSO under Medicare's postacute care transfer policy for the 10 specified DRGs.

Summary of Findings

Our review indicated that FCSO's payment system properly reduced payments to hospitals for claims related to the 10 specified DRGs which were coded as transfers to postacute care settings by the hospitals. However, we did find that overpayments resulted when the hospitals erroneously coded the claims as discharges instead of transfers.

Our review indicated that for the period October 1, 1998 through September 30, 1999, 26 of 100 sampled claims from the 10 specified DRGs coded as a discharge to home were erroneously coded because the beneficiary subsequently received postacute care. At the time of our review, the remaining 74 sampled claims were found to be appropriately reimbursed. Based on the sample results, we estimate that hospitals serviced by FCSO erroneously coded claims resulting in an overpayment for 26 percent of all "discharge to home" claims for the 10 specified DRGs.

The 26 erroneously coded claims in our sample resulted in excessive DRG payments of $37,788. Projecting this result to the 5,404 claims in our universe, we estimate that hospitals received $2,042,060 in excessive DRG payments as a result of these erroneous codings. These overpayments occurred because controls were not in place to ensure that the discharge code on the Medicare claim was correct.

As a long-term remedy, we recommend that the Health Care Financing Administration (HCFA) establish edits in its common working file (CWF) to compare beneficiary inpatient claims potentially subject to the postacute care transfer policy with subsequent postacute claims. This will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claim.

Pending implementation of CWF edits, we recommend that HCFA adopt these interim remedies:

- Issue a memorandum alerting FIs to the problems identified in our review and direct the FIs to re-emphasize to hospitals the importance of appropriate discharge status coding, with particular attention given to physician education regarding subsequent home health care.

- Instruct FIs to implement system edits in their system to identify inappropriately coded discharges when a postacute care claim is received. This would be applicable for claims for which the FI processes both the inpatient and postacute care claims.

- Instruct FCSO to recover the $37,788 in overpayments identified in our sample.

- Conduct a match using the CWF for the remainder of claims (totaling 5,304 claims) identified in our sampling universe of claims coded as discharges to home to identify and recover additional overpayments.

In partnership with HCFA, Office of Inspector General (OIG) audit staff will assist FCSO in implementing the last recommendation.

We are expanding our audit work to additional FIs to further quantify the magnitude of inappropriately coded claims.

The HCFA concurred with all of our recommendations. The HCFA response is attached to this report as APPENDIX C. The HCFA also made some technical comments, which we have incorporated into this final report.

BACKGROUND

Generally, discharges and transfers under PPS are defined under 42 CFR 412.4(a) and (b). A discharge is generally a situation in which a beneficiary is formally released from a PPS hospital after receiving complete acute care treatment. A case is generally considered to be a transfer for purpose of payment when the beneficiary is transferred from one PPS inpatient unit to another PPS unit within the same PPS hospital or to another PPS hospital for related care. Medicare regulations found in 42 CFR 412.4(f) provide that, in a transfer situation, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

In the framing of the Balanced Budget Act of 1997 (BBA), Congress was concerned that Medicare may be overpaying hospitals for patients who are transferred to a postacute care setting after a very short acute care hospital stay. Congress believed that Medicare's payment system should continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust PPS payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting. To address these concerns, Congress enacted section 4407 of the BBA.

Section 4407 of the BBA expanded the definition of transfer by adding section 1886(d)(5)(J) of the Social Security Act. Under this provision, if a beneficiary has a qualified discharge from 1 of 10 DRGs selected by the Secretary to a postacute care provider, the discharge will be treated as a transfer case beginning with discharges on or after October 1, 1998.

Section 1886(d)(5)(J)(ii) defines a qualified discharge as a discharge from a PPS hospital of an individual whose hospital stay is classified in 1 of the 10 selected DRGs if, upon discharge, the individual is:

- admitted to a hospital or hospital unit that is not reimbursed under PPS;
- admitted to a SNF; or
- provided home health services if the services relate to the condition or diagnosis for which the individual received inpatient hospital services and if these services are provided within an appropriate period as defined by the Secretary. According to 42 CFR 412.4(c)(3) the transfer policy is applicable if the individual was discharged to home under a written plan of care for the provision of home health services and the services begin within 3 days after the date of discharge.

Section 1886(d)(5)(J)(iii) gives the Secretary broad authority to select the 10 DRGs based on a high volume of discharges and a disproportionate use of postacute care services. According to 42 CFR 412.4(d) the 10 DRGs selected by the Secretary pursuant to this authority are as follows:

DRG	Title
014	Specific Cerebrovascular Disorders Except Transient Ischemic Attack
113	Amputation for Circulatory System Disorders Excluding Upper Limb and Toe
209	Major Joint Reattachment Procedures of Lower Extremity
210	Hip and Femur Procedures Except Major Joint Age > 17 with Complications and Comorbidities (CC)
211	Hip and Femur Procedures Except Major Joint Age > 17 without CC
236	Fractures of Hip and Pelvis
263	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC
264	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC
429	Organic Disturbances and Mental Retardation
483	Tracheostomy Except for Face, Mouth, and Neck Diagnoses

Medicare DRGs are sets of diagnoses that are expected to require about the same level of hospital resources to treat beneficiaries. The PPS reimburses hospitals a predetermined amount based on the DRG for each Medicare patient.

Responsibilities for Postacute Care Transfer Claims

In the preamble to a final rule published in the Federal Register on July 31, 1998 [63 Federal Register 40,954, 40,976 (1998)], HCFA indicated that hospitals need to maintain their responsibility to code the discharge bill based on the discharge plan for the patient, and if the hospital subsequently learns that postacute care was provided, the hospital should submit an adjustment bill. The HCFA acknowledged that hospitals will not always know if postacute care was rendered. However, the rule states that HCFA will monitor activity in this area to determine if hospitals are acting in good faith.

The HCFA contracts with intermediaries, usually insurance companies, to assist in administering the Medicare program. The FIs process inpatient hospital claims and some postacute care claims. Regional home health intermediaries process claims for home health agencies. The multiplicity of Medicare claims processors means that contractors may not have complete data on all of the care received by the beneficiary.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of this review was to examine the appropriateness of payments made by FCSO under Medicare's postacute transfer policy for the 10 specified DRGs.

Scope and Methodology

Our audit focused on Medicare inpatient claims with the 10 specified DRGs from PPS hospitals for which FCSO was the FI. Our review was limited to the period October 1, 1998 through September 30, 1999, the first full year that the 10 DRG postacute care transfer provision was in effect. During this period the FI processed about 592,000 inpatient hospital claims, of which 46,109 claims were for the 10 specified DRGs. Within the 46,109 claims we identified 8,483 claims that were coded by hospitals as if the beneficiary had been sent home with no postacute treatment. We further determined that of these 8,483 claims, 5,404 claims could potentially result in lower reimbursement to the discharging hospital if postacute care had been provided. These 5,404 claims constituted our audit universe.

We tested the claims payment system at FCSO to determine if payments to hospitals were accurately paid for claims coded as qualified transfers. We also tested the claims payment system at FCSO to determine if payments to hospitals were accurately paid for claims erroneously coded as discharges.

Tests of FCSO's payment system for claims coded as transfers

We reviewed payment system documentation concerning the transfer provisions, and selected a judgmental probe sample of claims which were coded as transfers for detailed review. The judgmental probe included claims from all 10 DRGs, which varied by discharge date, length of stay, provider number, and patient discharge status. For claims which were coded as a qualified transfer, we tested whether:

- appropriate modifications to the FI's payment system were made in accordance with legislation and subsequent HCFA guidance;
- the modifications were implemented timely;
- the modifications included all 10 specified DRGs; and
- payments were appropriately calculated.

The results of our judgmental probe sample indicated that no further audit work was warranted in this area.

Tests of FCSO's payment system for claims erroneously coded as discharges

We tested the system's ability to detect claims which were erroneously coded as a discharge to home by selecting a judgmental probe sample of claims with patient discharge status code 01. Discharge status code 01 is designated for use when a beneficiary is discharged to home with no postacute treatment. Claims which are correctly coded as 01 should be paid as a discharge at the full DRG rate. The claims in our judgmental sample varied by DRG, discharge date, length of stay, and provider number. The results of our judgmental sample indicated that additional review was necessary.

We, therefore, selected a statistically valid random sample (see APPENDIX A for details) of 100 claims from a universe of 5,404 claims with discharge status code 01 for detailed review. We determined the percent of claims that were coded in error and the amount of excessive payments made to the hospitals. (See APPENDIX B for details.)

Generally, for each of the 100 claims:

- we examined the CWF to determine if the beneficiary received postacute care as defined in legislation and regulation; and

- for claims erroneously coded as discharged to home when postacute care had indeed been provided, we calculated the variance in payment between what was actually paid and what should have been paid.

We did not review the overall internal control structure of the intermediary or of the Medicare program. We did not test the internal controls because the objective of our review was accomplished through substantive testing.

Our audit was performed at FCSO offices in Jacksonville, Florida between January 2000 and June 2000. Our audit was conducted in accordance with generally accepted government auditing standards.

DETAILED RESULTS OF REVIEW

Our review indicated that FCSO's payment system properly reduced payments to providers for claims related to the 10 specified DRGs which were coded as qualified transfers by the

providers. However, we did find that overpayments occurred when the FI received claims from hospitals that were erroneously coded as a discharge instead of a transfer.

Based on discussions with FCSO personnel, published HCFA guidance, and educational material given to the hospitals by FCSO, we determined that substantial reliance was being placed on the hospitals' diligence, willingness, and capability to appropriately code discharges.

Our review indicated that for the period October 1, 1998 through September 30, 1999, 26 of 100 sampled claims from the 10 specified DRGs coded as a discharge to home were erroneously coded. We found that the beneficiary had subsequently received postacute care, and, therefore, the claims should have been coded as a transfer.

Based on our sample results, we estimate that hospitals serviced by FCSO erroneously coded claims resulting in an overpayment for 26 percent of all "discharge to home" claims for the 10 specified DRGs.

The 26 erroneously coded claims in our sample resulted in excessive DRG payments of $37,788. Projecting our results to the 5,404 claims in our universe, we estimate that the hospitals received $2,042,060 in excessive DRG payments as a result of these erroneously coded claims. These overpayments occurred because controls were not in place to ensure that the discharge code on the Medicare claim was correct.

Criteria

Effective with discharges on or after October 1, 1998, a discharge from a PPS hospital with 1 of the 10 specified DRGs to a postacute care setting will be treated as a transfer case. The applicable postacute care settings are a hospital or hospital unit that is not reimbursed under PPS, a SNF, or home under a written plan of care for the provision of home health services with the services beginning within 3 days of the discharge.

Reimbursement for qualified discharges is made under one of two payment methods, each of which is designed to more closely match the reimbursement to the hospital's cost of providing care to the patient. In the event that the cost of providing care to a patient meets the criteria to be deemed an outlier, additional payment is allowed for the qualified discharges.

For DRGs 014, 113, 236, 263, 264, 429, and 483, hospitals are reimbursed at a graduated per diem rate for each day of the beneficiary's stay. Under this calculation method, the full DRG payment amount is divided by the geometric mean length of stay for the specific DRG to which the case is assigned. Twice the per diem amount is paid for the first day, and the per diem rate is paid for each of the remaining days, not to exceed the full DRG payment.

For DRGs 209, 210, and 211, the reimbursement is calculated as follows: on day one of a postacute care transfer, hospitals would receive one-half the DRG payment amount plus the per diem payment for the DRG. For each subsequent day prior to transfer, hospitals receive one-half the per diem up to the full DRG payment.

In the preamble to a final rule published in the Federal Register on July 31, 1998 [63 Federal Register 40,954, 40,976 (1998)], HCFA indicated that hospitals need to maintain their responsibility to code the discharge bill based on the discharge plan for the patient, and if the hospital subsequently learns that postacute care was provided, the hospital should submit an adjustment bill. The HCFA acknowledged that hospitals will not always know if postacute care was rendered. However, the rule states that HCFA will monitor activity in this area to determine if hospitals are acting in good faith.

The HCFA hospital manual (Medicare Hospital Manual, section 460) defines patient status code 01 as discharged to home or self care, meaning the patient needs no further care. Thus, if a patient is discharged from a hospital and requires postacute care, other patient status codes as defined by HCFA in their hospital manual, should be used.

Condition

In our sample of 100 claims coded as discharge to home, our audit revealed that 26 claims were improperly coded as discharges to home rather than to other postacute care. These 26 erroneously coded claims resulted in the discharging hospitals' receiving excessive payments relating to the 10 qualified discharge DRGs. The 26 claims were submitted by 16 different hospitals, with 1 hospital submitting 5 such claims. The erroneous claims included:

- 12 claims which were followed by a subsequent admission to an inpatient facility (non-PPS hospital or SNF) on the same day as the discharge date on the sample claim. These erroneously coded claims resulted in $15,237 in excess payments to the discharging provider. The 12 erroneously coded inpatient claims that resulted in excessive payments involved 9 discharges to SNFs and 3 to non-PPS rehabilitation facilities. We noted that 6 of the 12 erroneously coded claims occurred where the hospital and the postacute care provider were serviced by the same FI.

- 14 claims which were followed by a claim for home health services within 3 days of the discharge date on the sample claim. These erroneously coded claims resulted in $22,551 in excess payments to the discharging provider.

Cause

The claims in our sample were in error because the hospitals incorrectly coded the claims. Neither the FI nor the CWF have edits in place to identify and correct claims erroneously coded as discharged to home.

Effect

Our review found that 26 of the 100 claims were inappropriately coded and resulted in an overpayment. Based on our sample, we estimate that 26 percent of all claims submitted under the discharge to home status code were improperly coded and resulted in excessive reimbursement to the discharging hospital.

Projecting our results to the universe of claims for the period of October 1, 1998 through September 30, 1999, we estimate that the hospitals received $2,042,060 in excess payments. See APPENDIX B for the methodology used in projecting our sampling results.

RECOMMENDATIONS

As a long-term remedy, we recommend that HCFA establish edits in its CWF to compare beneficiary inpatient claims potentially subject to the postacute care transfer policy with subsequent postacute claims. This will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claim.

Pending implementation of CWF edits, we recommend that HCFA adopt these interim remedies:

- Issue a memorandum alerting FIs to the problems identified in our review and direct the FIs to re-emphasize to hospitals the importance of appropriate discharge status coding, with particular attention given to physician education regarding subsequent home health care.

- Instruct FIs to implement system edits in their system to identify inappropriately coded discharges when a postacute care claim is received. This would be applicable for claims for which the FI processes both the inpatient and postacute care claims.

- Instruct FCSO to recover the $37,788 in overpayments identified in our sample.

- Conduct a match using the CWF for the remainder of claims (totaling 5,304 claims) identified in our sample universe of claims coded as discharges to home to identify and recover additional overpayments.

In partnership with HCFA, OIG audit staff will assist FCSO in implementing the last recommendation.

We are expanding our audit work to additional FIs to further quantify the magnitude of inappropriately coded claims.

HCFA Comments

The HCFA concurred with all of our recommendations. The HCFA response is attached to this report as APPENDIX C. The HCFA also made some technical comments, which we have incorporated into this final report.

APPENDICES

APENDIX A

SAMPLING METHODOLOGY

Objective:

The objective of this audit was to determine the propriety of the payments relating to the 10 qualified discharges by FCSO. Effective October 1, 1998, the 10 qualified discharges are DRGs that are treated as transfers, rather than discharges, under section 1886(d)(5)(J) of the Act.

Population:

The population was 5,404 claims for the 10 DRGs specified by the Secretary with the discharge code of "discharged to home." These claims were paid by FCSO to hospitals during the period October 1, 1998 through September 30, 1999. The claims totaled $42,602,818.

Sample Unit:

The sampling unit was a DRG claim.

Sample Design:

A simple random sample was used.

Sample Size:

We selected 100 claims from the universe.

Estimation Methodology:

Using the Department of Health and Human Services, OIG, Office of Audit Services RAT-STATS Variable Appraisal Program for unrestricted samples, we projected the excessive payments to discharging hospitals resulting from erroneously coded claims. The erroneous payments were calculated by using the payment methods for these 10 DRGs as adopted under section 1886(d)(5)(J) of the Act.

APPENDIX B

SAMPLE RESULTS AND PROJECTIONS

Sample Results

Sample Size	Value of Sample	Number of Non-Zero Errors	Value of Errors
100	$671,485	26	$37,788

Variable Projections

Point estimate	$ 2,042,060
90% Confidence Interval	
Lower Limit	$ 1,380,265
Upper Limit	$2,703,855

Attributes Projection

We also used our random sample of 100 claims to project the percentage of claims in error. We used the Department of Health and Human Services, OIG, Office of Audit Services RAT-STATS Attribute Appraisal Program for unrestricted samples to project the percentage of claims in error. The results of these projections are presented below:

Sample Claims in Error:	26
Point Estimate:	26.000%
90% Confidence Interval	
Lower Limit	18.949%
Upper Limit	34.141%

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: JAN - 3 2001

TO: June Gibbs Brown
Inspector General

FROM: Robert A. Berenson, M.D.
Acting Deputy Administrator Robert A. Berenson M.D.

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Implementation of Medicare's Postacute Care Transfer Policy at First Coast Service Options," (A-04-00-02162)

Thank you for your report on the Health Care Financing Administration's (HCFA's) implementation of Medicare's postacute care transfer policy, which may reduce inpatient payments when prospective payment system (PPS) hospitals discharge beneficiaries in 10 specified diagnosis related groups (DRGs) to certain postacute care settings.

The PPS distinguishes between "discharges," situations in which a patient leaves an acute care (prospective payment) hospital after receiving complete acute care treatment, and "transfers," situations in which the patient is transferred to another acute care hospital for related care. In a transfer situation, full payment is made to the final discharging hospital and transferring hospitals are paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

The Balanced Budget Act of 1997 required the Secretary, beginning October 1, 1998, to treat as transfers all cases assigned to one of 10 DRGs selected by the Secretary if the individuals are discharged to a hospital excluded from payment under the PPS (psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals), or a skilled nursing facility, or home, if under certain circumstances the individual receives health care provided by a home health agency. Therefore, as of October 1, 1998, when a patient with one of the 10 DRGs is discharged from a PPS hospital and admitted to a non-PPS hospital on the same day, the discharge is considered a transfer and paid accordingly under the PPS (operating and capital) for inpatient hospital services. Similarly, a discharge from an acute care inpatient hospital paid under the PPS to a skilled nursing facility on the same date would be defined as a transfer and paid as such. We also consider home health services received within three days after a discharge to be a transfer if the services are related to the condition or diagnosis of the inpatient admission.

There has been evidence that, since the beginning of the PPS, hospitals have lowered the costs of care by shortening the time patients spend in the hospital and discharging them to postacute sites of care. Because PPS rates are based on a full course of hospital treatment, Medicare was paying twice for some aspects of care: once to the hospital, for less than a full course of treatment, and again to the postacute provider, which received the patient sooner and sicker and rendered services that should have been furnished by the hospital.

The postacute transfer policy benefits Medicare beneficiaries by providing incentives for hospitals to provide care in the most appropriate setting based on clinical rather than payment criteria. It also aligns payments more appropriately with the services provided, thus benefiting future beneficiaries by preserving the Medicare Trust Fund.

OIG found that 26 of 100 sampled claims were erroneously coded by the hospital as discharges to home when the patient in fact received subsequent postacute care. As a result, OIG recommends that HCFA adopt a long-term remedy of establishing edits in the common working file (CWF) to compare claims potentially subject to the postacute care transfer policy with subsequent claims. This would allow erroneous claims to be identified and appropriate adjustments to be made. We support this recommendation. This approach was discussed within HCFA prior to implementing the postacute care transfer policy, but was not put in place at the time due to the need to focus attention on Y2K readiness. We intend to pursue this approach in the next several months.

OIG also identifies a number of short term steps to ensure that hospitals accurately code discharge status for these situations. These recommendations and our responses are attached. We have also attached technical comments.

We appreciate the effort that went into this report and the opportunity to review and comment on the issues raised.

Attachment

Comments of the Health Care Financing Administration on the OIG Draft Report:
"Implementation of Medicare's Postacute Care Transfer Policy at First Coast Service Options"
(A-04-00-02162)

OIG Recommendation
Issue a memorandum alerting fiscal intermediaries (FIs) to the problems identified in our review and direct the FIs to re-emphasize to hospitals the importance of appropriate discharge status coding, with particular attention given to physician education regarding subsequent home health care.

HCFA Response
We concur. The findings do indicate a need for further education. In particular, 12 of the 26 erroneously coded claims in the sample involved a subsequent admission to a postacute care facility on the same day as the discharge date. Of these 12 claims, 6 occurred where the discharging hospital and the admitting postacute facility were serviced by the same FI. We will shortly be issuing the recommended program memorandum.

OIG Recommendation
Instruct FIs to implement system edits to identify inappropriately coded discharges when a postacute care claim is received. This would be applicable for claims for which the FI processes both the inpatient and postacute care claims.

HCFA Response
We concur. This is an important recommendation. Prior to implementing the change, we will assess whether the edits proposed by the OIG should be made at the individual FI level or across FIs at the CWF.

OIG Recommendation
Instruct First Coast Service Options to recover the $37,788 in overpayments identified in our sample.

HCFA Response
We concur that First Coast Service Options must recover any overpayments and the intermediary will review the data to determine the exact dollar amount of the overpayment. The OIG has agreed to furnish these documents to the regional office and the FI participating in the audit. We will forward a copy of the draft audit report to the regional office advising them to contact the OIG auditor for further instructions.

OIG Recommendation
Conduct a match using CWF for the remainder of claims (totaling 5,304 claims) identified in our sampling universe of claims coded as discharges to home to identify and recover additional overpayments.

HCFA Response

We agree. HCFA needs to aggressively monitor the implementation of this policy. We intend to develop a monitoring plan to look for patterns of miscoding across hospitals nationwide.